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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445406	A. BUILDING _____ B. WING _____	12/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY CARE OF RUTHERFORD	901 COUNTY FARM RD MURFREESBORO, TN 37127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual Recertification survey and investigation of complaint #30515 were completed on December 12, 2012, at Community Care of Rutherford. No deficiencies were cited in relation to the complaint under 42 CFR Part 482.13, Requirements for Long Term Care.	F 000	This Plan of Correction (POC) constitutes my written allegation of compliance for the deficiencies cited. However, submission of this POC is not an admission that a deficiency exists or that one was cited correctly. This POC is submitted to meet requirements established by state and federal law.	
F 159 SS=C	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds	F 159	**F159 Resident # 96** 12/27/12 – Facility Banking Policy was revised to reflect location of petty cash after normal business hours. Weekend banking will be available with the Activities Department .Residents have been informed of their right to remove all monies at their will, per their request via 1:1 visits, phone calls, and an article written for the January newsletter. 1/9/13 - Facility staff will be In-serviced regarding changes in Banking Policy by Administrator. 1/21/13 - Revised Banking Policy will be discussed in the Resident council Meeting. The policy is now posted throughout the facility. Resident satisfaction will be discussed each month during Resident Council and 1:1 visits by Activity and Social Service. All findings will be reported to the facility QAPI (Quality Assurance Performance Improvement) Committee for recommendation, education and intervention monthly for twelve months.	1/21/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator Amended POC 1/9/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 159	Continued From page 1 of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on interview and review of resident personal funds accounts, the facility failed to make funds available to residents on weekends for forty-four of forty-four residents with personal funds accounts. The findings included: Interview with resident #96 on December 10, 2012, at 2:46 p.m., in the J/K hall Dayroom, revealed the residents did not have access to money from their personal funds on the weekends. Further interview revealed the facility had staff available to distribute funds during business hours on weekdays and residents had to receive money by 4:00 - 5:00 p.m., on Fridays for the weekend. Review of the facility's list of residents with	F 159		

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F 159	Continued From page 2 personal funds accounts revealed the facility managed accounts for forty-four residents. Interview with the manager of the personal funds accounts on December 12, 2012, at 2:00 p.m., in the Front Office, confirmed the facility had two people available to dispense funds Monday through Friday between 7:00 a.m., and 5:00 p.m. Further interview confirmed the residents did not have access to money from their personal funds accounts on the weekends.	F 159		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain resident equipment and furniture in a sanitary manner. The findings included: Observation on December 11, 2012, at 9:45 a.m., of the rolling walker, over bed table, and dresser in room G11 by the A bed revealed the following: 1.) The rolling walker had a strip of tape hanging from the front left leg of the frame with the adhesive side blackened in color. 2.) A bandage was hanging off of the rear left leg of the rolling walker. Further observation revealed the pad of the bandage was stained. 3.) White residue was over the entire frame of the walker.	F 253	F253 – 12/11/12 Surveyor #1 interviewed housekeeper # 1 and confirmed the listed areas were in fact deficient. Housekeeper immediately corrected the deficient areas in G11A. Environmental Services Director was shown G11A by Surveyor # 1 who confirmed the deficient areas had been corrected. 12/21/12 Environmental Service Supervisor completed an audit of all walkers, over bed tables, and dressers. 100% of these items were clean at this time. 12/20/12 A weekly cleaning schedule was in serviced by the Environmental Service Director and reinforced regarding responsibilities and cleaning of these items. Preventative maintenance schedule and housekeeping audits will be conducted monthly by Environmental Services Supervisory staff. All findings will be forwarded to the facility QAPI (Quality Assurance Performance Improvement) Committee for recommendation, education and intervention.	1/26/13

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F 253	Continued From page 3 4.) The over bed table stem to leg area had a heavy accumulation of blackened debris. Further observation revealed the entire leg frame work had splatter debris and a white powdery residue present. 5.) The dresser top was covered with a white powdery residue. Interview on December 11, 2012, at 9:48 a.m., in room G11 by the A bed, with Housekeeper #1, confirmed the rolling walker had a strip of blackened tape hanging from the front left leg; had a bandage, with a stained pad, hanging from the rear left leg; and the frame of the walker was covered with a white powdery residue. Further interview confirmed the over bed table stem to leg area had a heavy accumulation of blackened debris, the leg area was splattered and had white powdery residue present. Further interview confirmed the dresser top had white powdery residue present.	F 253		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication;	F 272	*F272 Resident # 97* 12/12/12 – MD order for fluid restriction clarified for nursing and dietary service. Dietary Manager notified resident of change in fluid restriction and a note was made under the dietary section in the resident's record. 12/12/12 – Dietary Manager performed a record review on the only other resident with fluid restrictions and it was found to be accurate. The Director of Nursing in absence of the RD (Registered Dietician) will review with CDM (Certified Dietary Manager) the accuracy of the order for the fluid restriction in the resident's record. – for monthly orders.	

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F 272	Continued From page 4 Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, and interview, the facility failed to accurately assess the fluid needs for one (#97) resident of forty-one residents reviewed. The findings included: Resident #97 was admitted to the facility on November 20, 2012, with diagnoses including End Stage Renal Disease, Chronic Hepatitis C, and Atrial Fibrillation.	F 272	The Resident Care Coordinator will perform monthly audits of those residents on fluid restriction for 3 months for 100% compliance and then quarterly for 12 months to ensure compliance in calculation and consumption of fluids. All findings will be forwarded to the facility QAPI (Quality Assurance Performance Improvement) Committee for recommendation, education and intervention.	1/26/13

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F 272	Continued From page 5 Medical record review of a physician's order dated November 20, 2012, revealed "...1.5 L (liter) (1500 milliliters) QD (everyday) fluid restriction...": Medical record review of the Nutritional Progress Notes dated November 20, 2012, revealed "...Dietary will provide 720 ml (milliliters) daily-nursing 1080-charge nurse called dialysis clinic and was given 1.5 LtR (liter) fluid rest. (restriction)..." Medical record review of a physician's order dated November 21, 2012, revealed "...Clarification order: 1.5 liter Nursing to give 780 (every) day (and) dietary to provide 720 (every) day..." Medical record review of the physician's recapitulation orders dated December 1, 2012, through December 31, 2012, revealed "...1.5 L fluid restriction Dietary to provide 720 ml (and) nursing to provide 1080 ml..." Interview on December 12, 2012, at 12:45 p.m., with the Dietary Manager, in the conference room, confirmed the fluid needs were not assessed accurately. Dietary was to provide 720 ml and nursing to provide 780 ml, not 1080 ml, which would equal 300 ml of too many fluids.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate	F 278	*F278 Resident # 75* 12/12/12 – Resident's current MDS (October 31, 2012) was reviewed by LPN MDS Coordinator to ensure accuracy with correction for transfer of Stand by Assist with gait belt for transfers. 12/12/12 - Care Plan reviewed by the IDT (Interdisciplinary Team) to ensure accuracy to date – no revisions were necessary.	

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F 278	Continued From page 6 participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) for 1 resident (#75) of forty-one residents reviewed. The findings included: Resident #75 was admitted to the facility on January 1, 2012, with diagnoses of Chronic Obstructive Pulmonary Disease, Degenerative Joint Disease, Hypertension, DVT (deep vein thrombous), Delirium and Diastolic Dysfunction.	F 278	By January 20th – All MDSs, Section G and the resident care plans will be reviewed by IDT (Interdisciplinary Team) members to ensure accuracy of coding and care plans related to transfers. Therapy will continue to submit information related to ADL screens, evaluation and treatment to the MDS office for MDS completion. Therapy will review MDS data entry, Section G to ensure entry is accurate prior to signature. The Director of Nursing will designate an RN to perform random monthly audits of MDS's x 6 months to ensure compliance in ADL assessment, documentation and data entry. All findings will be forwarded to the facility QAPI (Quality Assurance Performance Improvement) Committee for recommendation, education and intervention.	1/26/13

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F 278	Continued From page 7 Medical record review of the thirty day scheduled MDS, dated October 31, 2012, revealed the resident had no cognitive impairment and required extensive assistance of two plus person for transfers. Medical record review of the Care Plan dated January 10, 2012, and updated on October 16, 2012, revealed "Assist me as needed with transfers using assist x 1 (times one person) /c (with) gait belt and rolling walker" for transfers and ambulation. Medical record review of the Physical and/or Occupational Therapy Screen Form dated October 3, 2012, revealed "transfers assist x 1 /c GB (with gait belt)". Review of the Plan of Treatment for Outpatient Rehabilitation dated November 8, 2012, revealed "D/C (discontinue) skilled PT (physical therapy) secondary to functional goals met ...transfers /c (with) mod (moderate) I (independence)". Observation of the resident on December 11, 2012, at 3:15 p.m., in the resident's room revealed the resident self transferred to the wheelchair in the bathroom. Interview on December 12, 2012, with Occupational Therapist #1 in the Physical Therapy Room at 8:01 a.m., revealed the resident was "stand by assist with gait belt" at discharge, the resident was "very happy that could get clothes out of the closet alone" and had been moderately independent during therapy. Interview with the MDS coordinator (Licensed	F 278		

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F 278	Continued From page 8 Practical Nurse (LPN) #2) in the MDS office on December 12, 2012, at 1:30 p.m., confirmed the MDS was coded inaccurately for transfers.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to revise the care plan for two residents (#108, #177) of forty-one residents reviewed. The findings included: Resident #108 was readmitted to the facility on	F 279	***F279 Resident # 108*** 12/11/12 – Resident comprehensive care plan reviewed and updated by the RN MDS Coordinator to include Hospice services. 12/11/12 – All residents currently on Hospice services was reviewed to ensure accurate inclusion of Hospice services on resident care plans. Review conducted by IDT (Interdisciplinary Team Members). 12/21/12–Social Service employees were in serviced by MDS Coordinator on completing a status change for each department at the time any Hospice contract is signed. IDT will ensure the care plans are updated timely to reflect resident current services 12/21/12 –Social Service employees will audit all new hospice contracts to ensure the plan of care is updated to reflect Hospice services for 3 months at 100% compliance, then quarterly thereafter. ***F279 Resident # 177*** 12/11/12 – Resident's comprehensive care plan reviewed and updated by the LPN MDS Coordinator to include MD order for placement, size and care of Foley catheter. She also reviewed the Treatment Record (TAR) and it reflects the MD order for care of Foley catheter.	

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F 279	Continued From page 9 November 30, 2012, with diagnoses including Chronic Obstructive Pulmonary Disease, Possible Lung Cancer, Debility, Chest Pain, and Dementia. Medical record review of a physician's order dated December 3, 2012, revealed effective November 30, 2012, the resident is under (named) hospice. Observation on December 11, 2012, at 3:55 p.m., revealed the resident lying on the bed sleeping, receiving oxygen at 2 liters per minute through a nasal cannula. Medical record review of the Care Plan reviewed on December 3, 2012, revealed no documentation the resident was receiving hospice services. Interview on December 11, 2012, at 4:20 p.m., with Registered Nurse #1, at the nursing station, confirmed the Care Plan reviewed on December 3, 2012, did not address the resident receiving hospice services. Resident #177 was admitted to the facility on December 4, 2012, with diagnoses including End Stage Liver Disease/Cirrhosis, Portal Hypertension, Ascites and Alcohol Abuse. Observation on December 11, 2012, at 4:13 p.m., revealed the resident lying on the bed, with a urinary catheter in place. Medical record review of a telephone order dated December 8, 2012, revealed place #16 urinary catheter, change every three weeks. Urinary catheter placed due to urinary retention. Foley	F 279	All residents with Foley catheters have the potential to be affected. On 12/27/12, 100% of all Licensed Nurses have been in serviced by the Staff Development Supervisor on care planning the MD order for the catheter at the time the order is received. MD orders for Foley catheter placement and care will continue to be reviewed in daily QA meeting, 12/21/12 – MDS office will perform monthly audits of MD orders and care plans x 3 months at 100% compliance and quarterly thereafter to ensure compliance and accuracy in plan of care. All findings will be forwarded to the facility QAPI (Quality Assurance Performance Improvement) Committee for recommendation, education and intervention.	1/20/13

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F 279	Continued From page 10 catheter care every shift. Review of the care plan updated December 5, 2012, revealed the care plan did not address the urinary catheter. Interview with Licensed Practical Nurse #2 (LPN) on December 11, 2012, at 4:50 p.m., at the F/G nursing station, confirmed the care plan had not been updated to address the urinary catheter placed on December 8, 2012.	F 279		
F 361 SS=F	483.35(a) QUALIFIED DIETITIAN - DIRECTOR OF FOOD SVCS The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis. If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian. A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to employ a qualified dietitian. The findings included:	F 361	F361 We currently do not have a Registered Dietician. Facility is actively pursuing (have interviewed and made an offer to) the services of a RD consultant either full-time, part-time, or on a consultant basis. In the interim, the DON will review dietary issues and intervene as needed. Upon execution of RD consultant agreement, the RD findings will provide dietary department direction. 1/26/13- Any concerns of the RD consultant will be forwarded to the facility QAPI (Quality Assurance Performance Improvement) Committee for recommendation, education and intervention.	1/26/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445406	A. BUILDING _____ B. WING _____	12/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY CARE OF RUTHERFORD	901 COUNTY FARM RD MURFREESBORO, TN 37127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 361	Continued From page 11 Interview on December 12, 2012, at 10:54 a.m., with the Administrator, in the Administrator's office, confirmed the facility did not employ a qualified full time, part time or contracted qualified dietitian.	F 361		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on interview, resident menu review, Resident Council Minutes review, and observation of food temperatures, the facility failed to provide food at the proper temperatures. The findings included: Interview with Resident #84 on December 10, 2012, at 3:38 p.m., revealed the food temperature was "Mostly cold. Had crab today, like it better than anything they make, and it was cold ..." Review of the resident menu revealed on December 10, 2012, the lunch included crab cakes. Interview with resident #34 on December 11, 2012, at 9:35 a.m., in the resident's room, revealed the food "at times was cold..." Review of the Resident Council Minutes revealed	F 364	***F364 Residents # 84, #34, #75*** 12/12/12 – Food delivery schedule is discussed and set per nursing, dietary and resident preference. On Admission, Resident dining preference discussion is held with each resident, CNA and charge nurse regarding resident preference for dining location and time. All residents have the potential to be affected. 12/12/12 – Dietary purchased new plate warmer lids to ensure plate temperature is appropriate when food is plated. On 12/14/12, 168 additional dinner plates were ordered so that plate warmer has time to warm plate's prior plating. 12/21/12 Dietary staff in-serviced by the CDM(Certified Dietary manager) to reload plate warmer with additional plates after each meal as part of the line cleanup and to cover the plate warmer with dome lids immediately. 1/9/13- All facility staff will be in-serviced by the CDM on meal service time and resident preparation for the meal, (i.e. toileting, dentures, hearing aid, etc.). She also will in-service staff on the process for meal tray delivery per closed cart to ensure warm temperatures are maintained.	

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F 364	Continued From page 12 the following: 1.) Dated May 29, 2012-" ...food was still being served cold and ...not going to eat cold food ..." 2.) Dated July 30, 2012-" ...would like food a little warmer ...tech (certified nurse technician) leave the doors to the food carts open, when (named Certified Dietary Manager (CDM)) is around the doors are shut, when (CDM) isn't the doors left open ..." 3.) Dated September 24, 2012-" ...Why is breakfast cold every morning?...". Observation in the dietary department of the resident breakfast meal service on December 11, 2012, beginning at 7:54 a.m., revealed the tray line was in progress and the cook obtained the following temperatures in degrees Fahrenheit: Scrambled eggs-200.9 Sausage patti-181 Oatmeal-208.3 Pureed eggs-194 Pureed sausage-204.4 Puree oatmeal-204.3 Milk in carton-40.1 Further observation, beginning at 8:13 a.m., on December 11, 2012, of the resident breakfast tray line revealed the test tray was placed in the food delivery cart containing eleven resident trays and the test tray. Continued observation revealed the food cart left the dietary department at 8:14 a.m., the food cart was delivered to the F + G Unit at 8:16 a.m., the first resident tray was delivered at 8:17 a.m., and the last resident tray was delivered at 8:34 a.m. Continued observation of the residents receiving trays revealed the last resident began eating at 8:45 a.m.	F 364	12/20/12 – CDM will monitor test tray at least weekly to ensure food temperature compliance and resident preference is established and maintained. Test trays will continue monthly to ensure on-going compliance. Resident Council, Social Service one-to-one visits and Activity one to-one visits will continue to inquire and offer opportunity for residents to discuss satisfaction with food service and temperature. 1/26/13-Concerns will be forwarded to the facility QAPI (Quality Assurance Performance Improvement) Committee for recommendation, education and intervention.	1/26/13

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F 364	Continued From page 13 Observation on December 11, 2012, beginning at 8:45 a.m., revealed the CDM obtaining the following temperatures, in Fahrenheit, of the test tray on the F + G food cart: Scrambled eggs-82 (a decrease of 118.9) Sausage-89.4 (a decrease of 91.6) Oatmeal-144.4 (a decrease of 63.9) Puree eggs-118.9 (a decrease of 75.1) Puree sausage-106 (a decrease of 98.4) Puree oatmeal-141.5 (a decrease of 62.8) Milk in carton-51.6 (an increase of 11.5) Interview, with the CDM on December 11, 2012, at approximately 8:50 a.m., in the F + G hall by the resident food cart, confirmed the test tray food temperatures were too low. Interview with the resident #75 on December 11, 2012, at 4:35 p.m., in the resident room revealed the resident complained of cold food. The resident always ate in the resident room, by choice and stated "most of time foods are cold, not warm".	F 364		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to complete laboratory services as ordered by the physician for one (#48) of forty-one residents reviewed.	F 502	***F502 Resident # 48*** 12/12/12 – MD was informed of CMP with Pre-Albumin that was not drawn in October by the Case Manager. 12/12/12 – CMP with Pre-Albumin was drawn and MD and POA notified of results by the charge nurse. 12/21/12 –100% of all active resident routine lab orders for the last four months were reviewed by Clinical Managers to ensure all lab orders were placed on Lab Calendar to ensure compliance	

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F 502	Continued From page 14 The findings included: Resident #48 was admitted to the facility on May 12, 2004, with diagnoses including Anoxic Brain Damage, Attention to Gastrostomy, Dysphagia, Aphasia, Convulsions, and Hypertension. Medical record review of the December 2012, physician's orders revealed "...CMP (Complete Metabolic Panel) with Pre Alubumin level Q (every) 6 months for dx (diagnosis) tube feed due 4/2012..." Medical record review revealed a CMP with a Pre Albumin level was completed on April 4, 2012, with a Pre albumin level of 5.8 (reference range 20.0 - 40.0). Medical record review revealed no documentation the CMP and Pre albumin level had been completed after April 4, 2012. Interview on December 12, 2012, at 9:45 a.m., with Licensed Practical Nurse (LPN) #1, at the nursing station confirmed the CMP with Pre-albumin was not completed as ordered.	F 502	12/27/12– All Licensed Nurses in-serviced on checking the lab roster at the end of every month by Staff Development Nurse to ensure all scheduled labs are placed on the calendar. All labs are checked daily by the Case Manager/Weekend Supervisor to ensure all scheduled labs are obtained. 1/26/13-The Resident Care Coordinator/Medical Records Nurse will audit all routine lab orders for 3 months for 100% accuracy and quarterly thereafter if warranted. All findings will be forwarded to the facility QAPI (Quality Assurance Performance Improvement) Committee for recommendation, education and intervention.	1/26/13